



# REIMBURSEMENT CLAIM FORM

109 Governor Street  
Madison Bldg., Ste UB-55  
Richmond, Virginia 23219  
1-800-523-6019 (VA only)  
804-864-7600

Name of Instructor: \_\_\_\_\_ SSN: \_\_\_\_\_  
[print]

Reimbursement payments may only be made to the individual who contracts with the Office of EMS to teach the reimbursed course. Only one Reimbursement Claim form may be submitted for payment for each course. \*Payment may only be made to the individual named above or a business in which this person is the sole proprietor or a principal partner.

## REIMBURSEMENT INFORMATION:

\*Make Payment to:

Mailing Address: \_\_\_\_\_ FIN or  
SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) - \_\_\_\_\_ Business Phone: ( ) - \_\_\_\_\_

Type of Program Taught: \_\_\_\_\_ Course #:: \_\_\_\_\_

Date Course Began: \_\_\_\_\_ Ended: \_\_\_\_\_

Hours Taught for Reimbursement: \_\_\_\_\_

Number of Students at third lesson of course: \_\_\_\_\_

Number of Students completing course: \_\_\_\_\_

I hereby certify that all information given on this Reimbursement Claim Form is correct and that I did not receive payment from any unapproved source for teaching this course.

\_\_\_\_\_  
[SIGNATURE]

\_\_\_\_\_  
[DATE]

### Office of EMS use only:

Number of hours requested for payment: \_\_\_\_\_

Amount paid for course: \$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_

Date Processed: \_\_\_\_\_ Total amount paid: \$ \_\_\_\_\_

Approved by: \_\_\_\_\_ Variance: \_\_\_\_\_

This form may be submitted directly to the Office of EMS or to State Test Site Staff.  
Instructor is encouraged to keep a copy for personal records.  
(Original form required for payment. - Fax or copy not acceptable)